BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: MARIO C., Claimant, and INLAND REGIONAL CENTER, Service Agency.	OAH No. 2006020055

DECISION

Gary Brozio, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Bernardino, California, on May 26, 2006.

Vince Toms, Senior Consumer Services Representative, appeared for the Inland Regional Center (IRC).

David Wazdatskey, Supervising Social Services Practitioner, and Rosie Mayzum, MSW, Social Services Practitioner, from the San Bernardino County Department of Children's Services, and Lisa Ector, aunt and foster parent of Mario C. (Claimant), represented Claimant at the hearing. Claimant was not present.

The matter was submitted May 26, 2006.

ISSUE

Does Mario C. have a developmental disability that qualifies him for regional center services under the Lanterman Act?

FACTUAL FINDINGS

Background

1. Claimant is a nine-year-old boy who comes from an extraordinarily difficult background. His mother was a drug user. There was a strong suspicion that his mother consumed drugs while she was pregnant with Claimant (methamphetamine). Claimant and his five siblings were homeless. He had little or no early education and did not come to the school system until he was five years old. There was a strong suspicion that he was physically abused. Finally, Claimant's mother abandoned him. One day when he was around five years old, Claimant's mother dropped him off at his aunt's house and never came back. Claimant now lives with that aunt, Lise Ector, who is his foster parent.

2. At the hearing, Mrs. Ector described Claimant's complex behavior. Claimant cannot tell time, write his name, read, or count money. He cannot toilet himself without making a mess, nor can he bathe without instructions. He cannot make his bed, put away his clothes, or button his shirts correctly. He is always cold and insists on wearing a sweater and long pants. He adjusts poorly to change, likes to wear the same shoes, and insists that they be tied before he puts them on. He is aggressive toward other children and does not interact well. He seldom shows affection. He must be supervised at all times, otherwise he peals walls, breaks things, climbs in the closet, gets on shelves, or runs away. He picks lint off carpet and picks the cotton fabric from the bottom of box springs. He bites and licks things, but the licking is designed to keep others from attaining objects like toys or food. He plays with sticks, paperclips, staples, and has broken most of his toys. He sometimes places his hands over his ears, rocks, and makes a moaning sound, but he does this to avoid things he does not like. He sometimes lies. He is often depressed, and says he misses his mother and wants her back. He takes medication but it only makes him tired.

3. Dr. Tracy Heindselman, Ph.D., a clinical psychologist with the Department of Behavioral Health (DBH), Mesa Clinic, had been working with Claimant in a social skills group and in individual therapy. She had worked with Claimant for three to four years, beginning in 2002. In her opinion, Claimant had impairments in (1) speech and language, (2) cognition (impulsivity, lack of attention), (3) self-regulation, (4) problem solving, (5) social skills (understanding and responding appropriately), (6) learning, (7) responding to caregivers, and (8) relationships.

4. IRC conducted Social Assessments of Claimant in June 2003 and November 2005. The most recent assessment showed that Claimant has a severe speech and language disorder, but it also described some of Claimant's abilities. Claimant could construct three to four word sentences, could print his name, could read simple words, and could point to desired objects. During the assessment, Claimant was "very tuned in to the conversation" with the service coordinator and his aunt, and covered up his ears when he did not like what was said. At home, Claimant could prepare simple foods without cooking, pour milk, and make toast. He could wash a bowl, and feel himself with spillage. If prompted and supervised, he could pick up toys, take out the trash, make his bed, tie his shoes, and perform

some personal hygiene needs. But he often did not want to. The Social Assessment also described Claimant's defiant and aggressive behavior. Although he initiated interaction with other children, he had little tolerance for them. He hit and kicked others and threw tantrums. He had emotional outbursts daily. He damaged property. He ran off when upset or when he did not get his way.

5. Claimant's most-recent Individual Education Program (IEP), dated April 11, 2006, identified him as emotionally disturbed. In school, the emotional disturbance did not allow him to "establish or maintain positive peer relationships." He lacked maturity and social skills. However, Claimant obeyed authority and could be redirected. He responded well to kinesthetic teaching, enjoyed math and science, and was very artistic. He was learning "age appropriate vocational skills." The IEP did not list Claimant as autistic or mentally retarded. He received no training or treatment for autism or mental retardation. No one from the school was called to testify about these circumstances.

6. It was undisputed that Claimant had significant disabilities, but there was no consensus on his diagnosis. In July 2003, independent clinical psychologist Clifford Taylor, Ph.D., diagnosed Claimant with Attention Deficit/Hyperactivity Disorder (ADHD), Learning Disorder NOS, Mixed Receptive-Language Disorder, and Borderline Intellectual Functioning. In September 2005, psychiatrist Lina Shuhaibar, M.D., with DBH, wrote a letter indicating that Claimant's symptoms were consistent with a diagnosis of Autistic Disorder, although notes from an earlier visit indicated she ruled out autism. In his November 2005 report and in his testimony, psychologist Bob Chang, Ph.D., of the IRC, diagnosed Claimant with Neglect of Child, Conduct Disorder, Psychotic Disorder NOS (provisional), and Academic Learning Disorder. In February 2006, psychiatrist Herman R. Clements II, M.D., diagnosed Claimant with Autistic Disorder, Learning Disability NOS, and ADHD, and ruling out mild mental retardation. In May 2006, Dr. Clements also wrote a letter stating that autism could not be ruled out despite Claimant's former diagnoses of posttraumatic stress disorder and bipolar disorder. In her outline and in her testimony, Dr. Heindselman, Ph.D., opined that Claimant met the criteria for autism and a condition similar to mental retardation.

7. Despite these numerous and varied diagnoses, only two experts testified. Dr. Chang testified that Claimant was not developmentally disabled (as defined by the Lanterman Act), and that he did not qualify for regional center services. Dr. Chang was extremely well-qualified and he gave a comprehensive explanation why Claimant was not autistic or mentally retarded. His conclusion was supported by a competent report completed by Dr. Taylor. Dr. Heindselman disagreed, stating that Claimant had autism or a condition similar to mental retardation, but she admitted that she was not an expert in autism and that she only had borderline expertise in mental retardation. The report of Dr. Clements and the letter of Dr. Shuhaibar also concluded that Claimant was autistic, but these written documents left far too many important questions unanswered. As a result, Claimant's evidence was not sufficient to demonstrate, by a preponderance of evidence, that he had a qualifying developmental disability. The reasons are discussed more fully below.

Autism

8. Dr. Heindselman testified that Claimant met the criteria for autism. She prepared an informal report designed to show how Claimant met the DSM-IV's criteria. The problem was that Dr. Heindselman was a specialist in child development and she had no formal training in autism. She admitted that she was not an expert in autism. She had not performed any formalized assessments for autism, and she did not conduct any formalized tests for autism in this case. Although Dr. Heindselman testified truthfully about her observations of Claimant and had his best interests in mind, her lack of expertise severely undercut the reliability of her opinion on autism. Moreover, Dr. Heindselman repeatedly testified that Claimant was a "complicated kid" with multiple diagnoses, but she did not explain why the alternate diagnoses were inadequate to explain Claimant's condition, or why autism was a necessary diagnosis in Claimant's case. She did not explain why Dr. Chang and Dr. Taylor reached the wrong conclusion.

9. Dr. Heindselman consulted with Dr. Shuhaibar about the diagnosis of autism, but Dr. Shuhaibar's diagnosis was problematic. On May 6, 2003, Dr. Shuhaibar's medical notes indicated that she ruled out a diagnosis of autism. Three years later she apparently changed her mind. In a one-page letter dated September 7, 2005, the doctor wrote that Claimant's cluster of symptoms was "consistent" with an autistic disorder. What caused the apparent change in diagnosis was a mystery. That change was not inconsequential because the DSM-IV required autism to be diagnosed by the age of three (an issue the doctor never addressed). Further, Dr. Shuhaibar gave no basis for her changed opinion, the report was silent about what sort of testing she conducted, and a number of the symptoms listed were either vague or were not relevant to the DSM-IV diagnosis for autism. Finally, the doctor's notes of September 15, 2005, showed that the doctor and Claimant's aunt had an argument or disagreement about the doctor's diagnosis. Serious questions arose about this notation given that it was made one week after Dr. Shuhaibar wrote the September 7 letter (containing a rather tentative diagnosis of autism and no mention of mental retardation). Likewise, serious questions arose about why Dr. Shuhaibar did not come to the hearing to testify under oath to her changed diagnosis. While there may be valid explanations for the doctor's change in diagnosis, and while the disagreement with the aunt might have been innocuous, no testimony was offered to explain these disquieting events. Nor was there testimony outlining the doctor's qualifications for rendering a diagnosis or the basis for her opinion. These circumstances did not inspire confidence.

10. These concerns spilled over onto Dr. Clements' report. Dr. Clements is a child and adolescent psychiatrist who, in a letter, professed to have experience diagnosing autism. He apparently saw Claimant for the first time on February 16, 2006. Claimant was brought in by his aunt *after* the apparent disagreement between the aunt and Dr. Shuhaibar. This was significant because Dr. Clements' report concluded that Claimant's delays and abnormal functioning (i.e. impaired social functioning, inability to develop peer relationships, lack of spoken language, stereotypic behaviors, and inflexibility) "occurred prior to the age of 3 . . . and continue to be prevalent at this time." There was no indication that Dr. Clements reviewed Claimant's medical, social, school, or psychological records, and so this

information had to come exclusively from the aunt. The aunt told the doctor that Claimant had "always been developmentally delayed as long as she ha[d] known him," but this was different than the information the aunt gave IRC in earlier assessments. Further, the report indicated that the aunt was "not answering" the doctor "with all of [Claimant's] developmental milestones." Thus, there was substantial doubt about the quality of the historical information Dr. Clements relied upon. In addition, it was questionable whether the doctor's mental status examination (apparently short in duration with no standardized tests) was sufficient to render an accurate diagnosis. The tentativeness of Dr. Clements' diagnosis was reflected in his letter of May 15, 2006, where he stated that Claimant "quite likely" met the criteria for autism and, at the same time, would not indicate "the level of disability." The meaning of this diagnosis was uncertain. Finally, the doctor's report failed to explain why autism was a necessary diagnosis in Claimant's case in light of the host of other diagnoses Claimant had received. There was no meaningful differential diagnosis. All this raised serious concerns about the reliability of the doctor's report.

11. Apart from the lack of a reliable diagnosis of autism, Dr. Chang made a compelling case that Claimant suffered from other disorders. Dr. Chang had been a staff psychologist with IRC for 20 years. He conducted about 200 assessments for autism a year, and over the past ten years, about two-thirds of his assessments involved autism. Dr. Chang cautioned that, in making diagnoses, care must be taken to assess all the available evidence and not overlook the most obvious reasons for a condition. In Claimant's case, that meant considering abandonment, neglect, and environmental deprivation, which were the most likely causes for his delay and social problems and indicated Neglect of Child and a possible Reactive Detachment Disorder. It also meant recognizing Claimant's tendency to be violent and angry, which indicated a Conduct Disorder. Also important was Claimant's attempt to hang himself with a seat belt, and his report of hearing voices and seeing the devil (auditory and visual hallucinations), which indicated a psychotic disorder and might later indicate schizophrenia. Finally, Claimant's scatter on the standardized tests showed a marked differential between academic scores and cognitive ability and indicated an Academic Learning Disorder.

12. Dr. Chang also identified several factors that helped rule out a diagnosis of autism. Paramount among these was the lack of symptoms occurring before age three, which was a critical aspect of the diagnosis under the DSM-IV TR. The initial social assessments at IRC did not identify symptoms before age three. Neither did the medical or school records. In fact, there was no significant evidence of autism at age five. Even today, the school district has not diagnosed Claimant with autism, and he is not receiving treatment or training for autism. Although Claimant licked toys and food, and he covered his ears and rocked while moaning, he did these things for a purpose – to get what he wanted or to avoid hearing what he did not want to hear. An autistic child's similar behavior would be automatic rather than purposeful. Claimant did not live in his own world, as do autistic children. He showed some social consciousness and used social phrases in context, which is highly unusual for an autistic child. In his testing with Dr. Chang, Claimant interacted, understood speech, displayed a level of social insight, completed tests, was friendly, and responded. Dr. Chang also noted Claimant's long, documented history of aggressive

behavior and depression might cause him to score lower on tests. As Dr. Chang explained, no single test confirmed or ruled out a diagnosis of autism, but the overall impression was not that of an autistic child.

13. Finally, Dr. Chang's opinion – that Claimant did not qualify for regional center services – was corroborated by Dr. Taylor's report. Although Dr. Taylor did not testify, his report gave a detailed list of tests he completed and the results of those tests. The report thoroughly described the background information Dr. Taylor considered. Therefore, the report was reliable, corroborating evidence that Claimant is not autistic.

Mental Retardation or a Disabling Condition Similar to Retardation

14. There was no evidence that Claimant was mentally retarded. Moreover, the evidence that Claimant suffered from a similar disabling condition was unconvincing.

15. Dr. Chang explained that, for a diagnosis of mental retardation under the DSM-IV TR, the person must have significantly sub-average general intelligence concurrent with adaptive deficits. Low intelligence is not enough. Under the Lanterman Act's so-called fifth category, the person must have a condition closely related to mental retardation or requiring similar treatment. Dr. Chang conducted the Wechsler Intelligence Scale for Children-Fourth Edition (WISC IV), and determined that Claimant was in the low average range in abstract thinking and comprehension; however, he had more severe deficits in speech, vocabulary, and memory. Dr. Taylor conducted the Wechsler Preschool and Primary Scale of Intelligence (WPPSI) test, and obtained a similar discrepancy in results. Dr. Chang explained that there was substantial scatter in the WPPSI and WISC IV tests, which made the full scale IQ less reliable. This is why Dr. Chang did not score the full scale IQ; however, Dr. Taylor did so. Dr. Taylor determined that Claimant's Verbal IQ was 72, his Performance IQ was 81, and his full scale IQ was 75, which is in the middle of the borderline range. The DSM-IV TR states that significantly sub-average intellectual functioning is evidenced by an IQ of about 70 or below. Although the Vineland Adaptive Behavior Scales, conducted by Dr. Taylor, showed Claimant was functioning considerably below age level, Dr. Chang found that the test was not indicative of mental retardation because (1) the test did not show the cause of the adaptive deficit, (2) the test did not document the adaptive potential, and (3) the test was given to Claimant only four to five months after he left the difficult environment of his birth family and low performance would be expected at this time. In addition, Claimant's scores might have been below his actual abilities because of his poor attention span and behavioral problems. Given the scatter in the tests and other factors, Dr. Chang believed it was important to place more weight on the overall impression. Here, the gap between academic scores and cognitive scores signified a learning disability. Claimant's low average intelligence was not indicative of mental retardation, or a similar condition.

16. Dr. Chang and Dr. Taylor concluded that Claimant was "[i]neligible for Regional Center services under the criteria of mental retardation, a similar condition to mental retardation and/or that requires similar treatment." In addition, in February 2006, Dr. Clements ruled out "mild mental retardation" and stated that more information needed to be

gathered regarding Claimant's Adaptive Behavior Scale and IQ score. Finally, Dr. Shuhaibar's notes from May 6, 2003, ruled out mental retardation. Although other documents in the record indicated that she may have changed her diagnosis on mental retardation, mental retardation was not mentioned in her most-recent letter of September 7, 2005.

17. Only Dr. Heindselman testified in favor of the theory of mental retardation. Dr. Heindselman had some training in mental retardation, intelligence testing, and the significance of results. She had worked closely with a few mentally retarded children. She admitted that Claimant did not have Downs Syndrome. She admitted that Claimant did not test as mentally retarded. Her theory was that Claimant's score was in the borderline range and so the confidence interval required a look at other factors. In her opinion, Claimant was low functioning and displayed features like retarded children. But she gave no details about why this was so. She made no effort to explain why no other expert rendered a diagnosis under the fifth category. Most importantly, Dr. Heindselman admitted that she only had borderline expertise in mental retardation. This evidence was insufficient to meet the burden of proof.

LEGAL CONCLUSIONS

The Lanterman Act

1. The Lanterman Developmental Disabilities Services Act (Act) is contained in the Welfare and Institutions Code. (Welf. & Inst. Code, § 4500 et. seq.) The purpose of the Act is to provide a "pattern of facilities and services . . . sufficiently complete to meet the needs of each person with developmental disabilities, regardless of age or degree of handicap, and at each stage of life." (§ 4501; *Association of Retarded Citizens v. Department of Developmental Services* (1985) 38 Cal.3d 384, 388.)

Developmental Disability

2. Section 4512, subdivision (a) of the Act defines a developmental disability as follows:

> "(a) 'Developmental disability' means a disability that originates before an individual attains age 18 years, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual. As defined by the Director of Developmental Services, in consultation with the Superintendent of Public Instruction, this term shall include mental retardation, cerebral palsy, epilepsy, and autism. This term shall also include disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation, but shall not include other handicapping conditions that are solely physical in nature."

3. Section 54000 of Title 17 of the California Code of Regulations further defines the term developmental disability:

> "(a) 'Developmental Disability' means a disability that is attributable to mental retardation, cerebral palsy, epilepsy, autism, or disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation.
>
> (b) The Developmental Disability shall:
>
> (1) Originate before age eighteen;
>
> (2) Be likely to continue indefinitely;
>
> (3) Constitute a substantial disability for the individual as defined in the article.
>
> (c) Developmental Disability shall not include handicapping conditions that are:
>
> (1) Solely psychiatric disorders where there is impaired intellectual or social functioning which originated as a result of the psychiatric disorder or treatment given for such a disorder. Such psychiatric disorders include psycho-social deprivation and/or psychosis, severe neurosis or personality disorders even where social and intellectual functioning have become seriously impaired as an integral manifestation of the disorder.
>
> (2) Solely learning disabilities. A learning disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psycho-social deprivation, psychiatric disorder, or sensory loss.
>
> (3) Solely physical in nature. These conditions include congenital anomalies or conditions acquired through disease, accident, or faulty development which are not associated with a neurological impairment that results in a need for treatment similar to that required for mental retardation.

Burden of Proof

4. In a proceeding to determine eligibility, the burden of proof is on the Claimant to establish he or she meets the proper criteria. The standard is a preponderance of the evidence. (Evid. Code, § 115.)

The Evidence Was Not Sufficient to Establish That Claimant Was Eligible for Regional Center Services

5. Claimant's major contention was that he qualified for regional center services under a diagnosis of autism. The evidence was not sufficient to support this contention. First, there was no reliable evidence that, prior to the age of three, Claimant manifested delays or abnormal functioning consistent with autism. The only evidence of early manifestation came from the aunt, but her description of Claimant's symptoms changed over time and her testimony often seemed at odds with Claimant's most recent IEP and Social Assessment. There were no medical records, school records, or dependable eyewitnesses corroborating an early onset of autism. Finally, the school district has never considered Claimant to be autistic. Thus, there was fundamental lack of historical data to support a diagnosis of autism. The basic foundation for the diagnosis was missing.

6. Second, Claimant's expert witnesses were not convincing. Although a person can be diagnosed as autistic in the absence of reliable historical data, the diagnosis must be based on more-reliable expert opinion evidence than was presented here. Dr. Heindselman was not qualified to render a diagnosis on autism. Dr. Shuhaibar may have been qualified to render such a diagnosis, but that fact was not established. Moreover, her reports were highly problematic, starting with the fact that she apparently changed her diagnosis and there was no explanation why. Dr. Clements was likely qualified to render an opinion on autism, but it appeared that he rendered his opinion on incomplete and unreliable information. He was also unwilling to identify the level of disability, which raised serious concerns under the Lanterman Act. (See Welf. & Inst. Code, § 4512, subd. (l).) Moreover, none of the experts rendered a qualified differential diagnosis, which was critical in this case given that Claimant is very complex and difficult to diagnose. In short, these expert opinions did not demonstrate, by a preponderance of evidence, that Claimant was autistic.

7. Third, Dr. Chang determined that Claimant was not autistic. Dr. Chang's testimony was compelling because (1) he was shown to be the most qualified expert in the proceedings, (2) he considered the most-likely causes of Claimant's condition, (3) he considered the most-comprehensive background material, (4) he personally conducted testing on Claimant, and (5) he conducted a complete differential diagnosis. Moreover, his conclusion - that Claimant was not autistic – was corroborated by Dr. Taylor, whose report was the second most-reliable evidence in the proceedings.

8. Claimant's ancillary contention was that he qualified for regional center services under a diagnosis of mental retardation or a similar condition. There was no reliable evidence that Claimant was mentally retarded. The real issue was whether Claimant qualified for regional center services under the fifth category. "The fifth category condition must be very similar to mental retardation, with many of the same, or close to the same, factors required in classifying a person as mentally retarded." (*Mason v. Office of Administrative Hearings* (2001) 89 CalApp.4th 1119, 1129.) It also requires a showing of the other various factors required by the Lanterman Act, including a substantial disability. (*Ibid.*)

9. Dr. Chang concluded that Claimant did not qualify for services under the fifth category because Claimant's condition evidenced a learning disability and not a condition similar to mental retardation. Dr. Chang's highly qualified opinion was entitled to considerable deference. (*Mason, supa,* 89 CalApp.4th at 1131.) Dr. Chang's opinion was also corroborated by Dr. Taylor, who, once again, provided the second most reliable evidence in this case. In addition, two of Claimant's own experts failed to conclude that Claimant qualified for services under the fifth category. Dr. Shuhaibar appeared to early on rule out mental retardation, and her most-recent letter did not mention mental retardation or the fifth category. Dr. Clements ruled out mild mental retardation, at least until more tests could be completed. Dr. Heindselman thought Clamant ought to qualify for regional center services under the fifth category, but her testimony was replete with deficiencies, including her lack of significant expertise. This evidence was insufficient to prove, by a preponderance of evidence, that Claimant qualified for regional center services under the fifth category.

10. Finally, it bears mention that Claimant has had a multitude of different diagnoses. He is indisputably difficult to diagnose. One reason might be the lack of detailed and reliable data about Claimant's childhood prior to the age of five. Another reason might be that Claimant has a multitude of significant factors contributing to his condition, i.e. maternal drug use, abandonment, homelessness, physical abuse, and neglect. Other reasons might include a vast difference in the amount of data considered by experts, the reliability of the historical data considered by experts, the degree of testing performed by experts, and Claimant's mood or motivation when being tested. All this bears directly on the burden of proof. These circumstances raise serious doubts about the recent emergence of the diagnoses of autism, mental retardation, or a similar condition. In the face of so much evidence contradicting these diagnoses, far more authoritative expert opinion evidence would be necessary to overcome "the technical expertise of the administrative officers and experts" rendering alternate diagnoses in this case. (See *Mason, supra,* 89 CalApp.4th at 1131).

11. These conclusions are based on all the factual findings and legal conclusions.

ORDER

The IRC's conclusion, that Claimant does not have a developmental disability, is upheld. Claimant failed to meet his burden of proof that he is entitled to regional center services under the Lanterman Act.

DATED: _____

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GARY BROZIO
Administrative Law Judge
Office of Administrative Hearings